STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING 00			COMPLETED	
		155567	B. WIN			06/27/	2013	
NAME OF B	DOLUMEN OF GLIPPI HER				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIEF	C		1400 M	EDICAL PARK DR			
UNIVERS		H AND REHABILITATION CENT	ER	FORT V	VAYNE, IN 46825			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG F000000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE	
F000000								
	This visit was for	the Investigation of	F00	0000				
	Complaint IN0013	_						
	Complaint ii voore	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	Complaint							
	IN00130877-Subs	stantiated,						
	Federal/State Def	ficiencies related to						
	the allegations are	e cited at F-240 and						
	F279.							
	Unrelated deficier	ncy is cited.						
	Survey Dates: Ju	ıne 26 & 27, 2013						
	-							
	Facility number:	000459						
	Provider number:	155567						
	AIM number:	100289700						
	Survey team:							
	Angela Strass, RN	N						
	,go.a oaoc,							
	Census bed type:							
	SNF: 4							
	SNF/NF: 72							
	Total: 76							
	Conque novembre							
	Census payor typ							
	Medicare: 14							
	Medicaid: 52	2						
LABORATOR	Y DIRECTOR'S OR PPO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATUR	7	TITLE		(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/27/	ETED		
	PROVIDER OR SUPPLIER	H AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR TER FORT WAYNE, IN 46825					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Other: 10 Total: 76							
	Sample: 3							
	These deficiencies findings cited in ad IAC 16.2.	s also reflect state ccordance with 410						
	Quality review cor 2013 by Randy Fr	mpleted on June 28, y RN.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155567	B. WING			06/27/	2013
NAME OF D	ROVIDER OR SUPPLIER		•	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	KOVIDER OR SUFFLIER				MEDICAL PARK DR		
UNIVERS	SITY PARK HEALTI	H AND REHABILITATION CENTE	R	FORT	WAYNE, IN 46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000226 SS=D	ETC POLICIES	MENT ABUSE/NEGLECT, develop and implement					
	written policies ar	nd procedures that prohibit glect, and abuse of					
		sappropriation of resident					
	Based on interview	w and record	F00	0226	I. It is the policy and procedure	e of	07/25/2013
	review, the facility	failed to report			University Park to report all occurances related to F- tags		
	misappropriation of	of resident property			224,225,226 to all Regulatory		
	to local law enforc	cement for 1 of 3			agencies, and local law		
	resident records re	eviewed and failed			enforcement, A. Resident A's occurance and allegation of		
	to ensure the facil	lity policy was			missing money was reported to	0	
	accurate as direct	ed by the Center for			the local law enforcement agency, and other regulatory		
	Medicare and Med	dicaid Services.			agencies.II. No other residents		
	Finding includes:				were affected, as evidenced be the investigation tools of interviews of residents and states (see attachment#1)III. The investigation management too	ff.	
	On 6/26/13 at 7:30	0 a.m. interview with			has been updated to reflect the		
	resident (A) indica	ated she had \$80.00			tab for the local law enforcement		
	missing from her r	room. The resident			notification. (see attachment #2).IV. The tools will be used i	n	
	indicated she had	put the money in a			the event of any allegation, to		
	little coin purse in	her purse and had			ensure compliance of reporting appropriately. These will be	9	
	put it in her drawe	er. The resident			brought to the monthly QMP		
	indicated the facili	ity was not going to			meetings to ensure		
	replace her missin	ng money.			100% compliance is achieved and reviewed by the committe for 6 months.V. 7/25/13	e,	
	On 6/26/13 at 8:05	5 a.m. the Director					
	of Nursing (DON)	was queried about					
	the residents miss	sing money. The					
	DON indicated res	sident (A) had in the					
			l				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155567			ILDING	nstruction 00	(X3) DATE S COMPLI 06/27/2	ETED	
NAME OF I	PROVIDER OR SUPPLIE	R	_ <u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
		TH AND REHABILITATION CENT	ED		EDICAL PARK DR		
		STATEMENT OF DEFICIENCIES	EK	<u> </u>	VAYNE, IN 46825		(7/5)
(X4) ID PREFIX		NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	past stated she h	ad missing money					
	and they had rep	laced it but not this					
	time. Further inte	erview indicated the					
	facility had invest	igated the missing					
	money and repor	ted the incident to					
	the State Departr	ment of Health,					
	Ombudsman and	I Adult Protective					
	Services. On 6/2	26/13 at 8:40 a.m. the					
	Administrator and	d DON were queried					
	if they had report	ed the missing					
	money to the poli	ice and they					
	indicated they ha	d not. At 10:00 a.m.					
	on 6/26/13 the Ad	dministrator					
	presented the wri	iter with a piece of					
	paper with a repo	ort number written on					
	it and indicated s	he had reported the					
	incident of the mi	ssing money for					
	resident (A) to th	ne local police					
	department. Inte	rview with the					
	Administrator ind	icated she did not					
	know she was to	report to the police,					
	and had followed	the facility policy.					
	On 6/27/13 at 11	:30 a.m. the facility					
		sented the facility					
	policy "Abuse Pre	•					
		estigation & Crime					
	Reporting Policy"	_					
	revision date of D						
	Tevision date of L	COOMING! ZUIZ.					
	ĺ						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155567	B. WIN			06/27/	2013
NAME OF P	PROVIDER OR SUPPLIER	· ?			ADDRESS, CITY, STATE, ZIP CODE		
					EDICAL PARK DR		
		H AND REHABILITATION CENTE	:K		VAYNE, IN 46825		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Review of the faci	ility policy on					
	6/27/13 at 11:45 a						
	following:						
	i i i i i i i i i i i i i i i i i i i						
	"Regulations requ	uire employees that					
		to elderly persons or					
	dependant adults	• •					
	reporters) to repo	rt instances of					
	suspected or alleg	gations of abuse,					
	neglect, or misap	propriation of					
	resident property	to the local					
	ombudsman or lo	cal law enforcement					
	agency and to Sta	ate Licensing and					
	Certification imme	ediately or as soon					
	as practically pos	sible within 24 hours					
	of detection."						
	On 6/27/13 at 12:	40 p.m. the					
	Administrator and	I DON were					
	informed of a Dire	ective by CMS					
	(Center for Medic	are and Medicaid					
	Services) dated 6	5/17/11 and revised					
	on 8/12/11 which	indicated reports of					
	suspicion of a crir	me must be					
	submitted to at lea	ast one law					
	enforcement ager	ncy of jurisdiction					
	and the State Age	ency.					
	3.1-28(a)						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey Pleted 7/2013			
UNIVERS		H AND REHABILITATION CENTI	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			ETED	
		155567	B. WING 06/27/2013			2013	
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				MEDICAL PARK DR		
UNIVERS	SITY PARK HEALTI	H AND REHABILITATION CENTER	₹		WAYNE, IN 46825		
(X4) ID		TATEMENT OF DEFICIENCIES	PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG F000240	483.15	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
SS=D	CARE AND ENVI QUALITY OF LIF A facility must car manner and in an	RONMENT PROMOTES E re for its residents in a nenvironment that nance or enhancement of					
	each resident's qu	uality of life.					
	Based on record r	review and interview	F00	0240	I. It is the policy and procedure University Park to provide care		07/25/2013
	the facility failed to	ensure personal			a manner to enhance the	5 111	
	care products wer	e available for 2 of			residents lives.A. Resident A's		
	13 residents interv	viewed.			care plan updated to reflect he current status and behaviors of		
	Finding includes:				use of the incontinence products. B. her usage and size of incontenance products were re-evaluated for		
	On 6/26/13 from 5	5:15 a.m. through			appropriateness. II. No other		
	6:15 a.m. observa	tion indicated there			residents were affected, a aud other residents who use	lit of	
	were 8 nursing sta	aff members			incontenance products,		
	working. The 8 er	mployees were			completed, (see attachment # to ensure that they are reciev		
	interviewed related	d to the availability			the products daily.III. A	Cirig	
	of incontinence pa	ads and briefs for			emergency supply of		
	the residents. 7 of	the 8 staff			incontenance products will be kept in the Nurses med room	for	
	members indicate	d they would run			immediate access to staff, B.	- l	
	out of incontinence	e products and			Staff assigned to Central Supplies will pass all personal supplies		
	would have to bor	row from other			a daily basis in the AM to ensu	ıre	
	residents to provid	de for some of the			continuity of supplies. Evaluation of resident needs and use of	on	
	residents who did	not have products			products will be reviewed.IV.		
	available. The sta	aff indicated they			Don/Designee will do weekly		
	did not have acces	ss to the supply			random audits, to ensure that supplies are being passed and		
	room to get more	if needed and would			that continuity of supplies is		
	borrow from other	residents. During			maintained. These will be brou to monthly QMP meetings for	ght	
	the interviews staf	ff indicated there			review by the committee, for 6		
	were times when t	they had to use the			months.V. 7/25/13		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155567	B. WIN			06/27/20) is
NAME OF F	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SITY PARK HEALT	H AND REHABILITATION CENT	ER	1	VAYNE, IN 46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (COMPLETION DATE
		on residents due to					
	residents not havi						
	rooms.						
	On 6/26/13 at 7:5	0 a.m interview with					
	resident (A) indica	ated she used					
	urinary incontinen	ce pads but often					
	ran out of those p	ads. During further					
	interview with the	resident she state					
	she would use tov	vels in place of the					
	pads. The reside	nt stated the facility					
	staff only give her	3 pads at a time.					
	The resident indic	ated she currently					
	was using a towel	, and showed the					
	writer that she kee	eps her pads in her					
	top dresser drawe	er and there were no					
	pads available.						
	On 6/26/13 at 8:0	0 a.m. the Director					
	of Nursing (DON)	was asked to come					
	to the resident's ro	oom and speak to					
	her about the issu						
	entered the room	and observed the					
	resident in the bat	throom with the					
	towel she had bee	en using. The DON					
	searched the resid	dent's room and was					
	unable to find any	incontinence pads					
	in the resident's ro	oom. Staff were					
l	then directed to g	et the resident pads.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155567	B. WIN			06/27/20)13
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SITY PARK HEALT	H AND REHABILITATION CENT	ER		EDICAL PARK DR VAYNE, IN 46825		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG			DATE
		5 a.m. interview with					
		licated she worked					
		and was directed to					
		ence products daily.					
		et of residents with					
	·	ds they were to have					
		the record indicated					
	resident (A) was t	o be provided 3					
	pads daily.						
	Interview with the	DON on 6/27/13 at					
	12:00 p.m. indicat	ted resident (A) was					
	able to toilet herse	elf and was					
	constantly changi	ng her incontinence					
	pads. "We contin	ually give her pads.					
	I could give her 40	0 pads and she					
	would go through	them." The DON					
	was queried abou	t the list of the					
	number of pads re	esidents were to be					
	given daily, and sl	he indicated the					
	residents on the li	st who were to get 3					
	pads daily were u	sually continent					
	throughout the da	y.					
	On 6/26/13 at 9:0	0 a.m. review of the					
	"List" provided by	employee #11					
	indicated 48 resid	lents were on the					
	list. At the bottom	n of the page,					
	highlighted in yello	ow was written					
	"These residents	only get 3 per day."					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	NSTRUCTION 00	(X3) DATE COMPL 06/27	ETED		
	PROVIDER OR SUPPLIER	H AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
TAG	There were 28 res who were to get 3 day. Interview with resi at 12:15 p.m. indic facility ran out of be resident stated sh up and out of bed hours until the fac obtain the briefs. indicated she nee the facility did not morning.	dent (D) on 6/27/13 cated last week the priefs for her. The e was unable to get that morning for 4 ility was able to The resident ded large briefs and		TAG	DEFICIENCY)		DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	SURVEY ETED			
		155567	A. BUILI B. WING		00	06/27/	
NAME OF D	ROVIDER OR SUPPLIE	D	B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
		`` TH AND REHABILITATION CENTE	R		EDICAL PARK DR VAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	_	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F000279 SS=D	PLANS A facility must us assessment to de the resident's concare plan for each measurable object meet a resident's mental and psycidentified in the concare plan meet are to be further esident's high mental, and psycrequired under set that would other set that w	se the results of the evelop, review and revise mprehensive plan of care. develop a comprehensive ch resident that includes ectives and timetables to se medical, nursing, and hosocial needs that are comprehensive assessment. ust describe the services mished to attain or maintain phest practicable physical, chosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10, and to refuse treatment under view and interview the facility that a behavior plan of care for 1 timple of 3 resident records a.m. interview with resident (A) urinary incontinence pads but one pads. During further resident she state she would use the pads. The resident stated ly give her 3 pads at a time, atted she currently was using a	F000)279	I. It is the policy and procedure University Park to develope arimplement care palns specific each residents needs. Resider A's care plans were reviewed updated to reflect her current behaviors.II. There were no ot residents affected, A audit of resident care plans (who are obehavior management program) was done to ensure they currently relfect the reside who have behaviors. (see attachments #4)III.	nd to nt and her on	07/25/2013
		the writer that she keeps her sser drawer and there were no			careplans in the monthly Beha management meetings, to ens that they reflect the current		

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	VI OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
	155567	B. WING		06/27/2013
		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	PROVIDER OR SUPPLIER		EDICAL PARK DR	
UNIVERS	SITY PARK HEALTH AND REHABILITATION CENTE		WAYNE, IN 46825	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
TAG		IAG	behaviors of residents on the	
	On 6/26/13 at 8:00 a.m. the Director of Nursing (DON) was asked to come to the resident's room		behavior management care	
	and speak to her about the issue. The DON		plans.IV. The behavior	
	entered the room and observed the resident in the		management meetings notes	will
	bathroom with the towel she had been using. The		be brought the the QMP mee	
	DON searched the resident's room and was unable		monthly for review by commit	_
	to find any incontinence pads in the resident's		for 6 months.V. 7/25/13	
	room. Staff were then directed to get the resident			
	pads.			
	<u> </u>			
	Interview with the DON on 6/27/13 at 12:00 p.m.			
	indicated resident (A) was able to toilet herself			
	and was constantly changing her incontinence			
	pads. "We continually give her pads. I could give			
	her 40 pads and she would go through them."			
	Further interview with the DON indicated the			
	issue with resident (A)using so many incontinence			
	pads was a behavior. The DON was further			
	queried about a plan of care to address the			
	behavior, and she indicated they did not have a			
	plan to address the behavior.			
	2.1.25(a)			
	3.1-35(a)			

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